PRINTED: 05/19/2009 DEPARTMENT OF HEALTH AND HU N SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 295044 04/21/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD **HEARTHSTONE OF NORTHERN NEVADA** SPARKS, NV 89434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 000 F 000 INITIAL COMMENTS This Plan of correction is prepared and executed because it is required by the provisions of This Statement of Deficiencies was generated as the state and federal regulations the result of a Medicare complaint investigation and not because Hearthstone of which was completed on 4/21/09. Seven records Northern Nevada agrees with were sampled. the allegations and citations listed on the statement of The survey was conducted in accordance with 42 deficiencies. Hearthstone CFR Chapter IV Part 483 Requirements for maintains that the alleged States and Long Term Care Facilities. deficiencies do not, individually and collectively, jeopardize the The following complaint was investigated: health and safety of the residents, nor are they of such Complaint #NV21850 - Substantiated (F Tags character as to limit our capacity 157, 309, 325, 441) to render adequate care as prescribed by regulation. This The findings and conclusions of any investigation plan of correction shall operate by the Health Division shall not be construed as as Hearthstone's written prohibiting any criminal or civil investigations, credible allegation of actions or other claims for relief that may be available to any party under applicable federal, compliance. state, or local laws. By submitting this plan of The following regulatory deficienices were correction, Hearthstone does identified. not admit to the accuracy of the F 157 F 157 483.10(b)(11) NOTIFICATION OF CHANGES deficiencies. This plan of \$S=G A facility must immediately inform the resident; correction is not meant to establish any standard of care, consult with the resident's physician; and if contract, obligation, or position, 5-22-0 known, notify the resident's legal representative and Hearthstone reserves all or an interested family member when there is an accident involving the resident which results in rights to raise all possible contentions and defenses in any injury and has the potential for requiring physician civil or criminal claim, action or intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a proceeding. deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment MAY 2 8 2009 significantly (i.e., a need to discontinue an

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

existing form of treatment due to adverse

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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## DEPARTMENT OF HEALTH AND HU I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295044				JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		295044	B. WIN	G	04/:	C 21/2009
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA				STREET ADDRESS, CITY, STATE, ZIP C 1950 BARING BLVD SPARKS, NV 89434	•	172003
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	treatment); or a decent decent from the facility must also and, if known, the ror interested family change in room or specified in §483.1 resident rights under regulations as specified in section.  The facility must resident rights under regulations as specified in section.  The facility must restricted the address and phased or interview failed to notify the production in a timeline residents (#2, #3).  Findings include:  Resident #2 was a 1/15/09, with diagnostic disease, failure to a therosclerosis, confibrillation, anemia, resident's legal reperforming peritoner.	commence a new form of cision to transfer or discharge he facility as specified in so promptly notify the resident resident's legal representative member when there is a roommate assignment as 15(e)(2); or a change in the resident or State law or cified in paragraph (b)(1) of cord and periodically update none number of the resident's a or interested family member.  Note that the facility of cord and record review, the facility on the properties of the resident's properties of the resident in the resentative had been the resident of the resident of the resident of the resident of the resident in the resident of the	F 1		of Changes  3 have in the the facility be ce are as  nursing at e in leted by the ition report ible to be attached t.  n's actitioner romptly ge nurse of a	5-22-9

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	295044		B. WIN			C 04/21/2009	
	PROVIDER OR SUPPLIER			19	EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434		112000
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F 157	Record review reversident assessme 4. Cognitive skills dated 1/22/09, that been independent "decisions being concerned review revesummary dated 1/2 checked: "Alert, mestaff names/faces, decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - staff names home; decision making - is summary dated 1/2 recall - is summary d	ealed a Minimum Data Set int for Resident #2: Section B., for daily decision making, showed that the resident had in decision making with onsistent/reasonable."  ealed a weekly nursing 22/09, with the following boxes emory recall - current season, that he was in a nursing home; independent. A weekly nursing 28/09, read: Alert, memory of faces, that he is in a nursing king - independent."  ealed a physician's progress that read: "Abdomen: normal, " ealed that Resident #2 had an acute care facility on	F	157	Nurses will be required to complete walking rounds with the incoming replacement nurse.  This will be monitored on a day basis for change in condition the 24 hour report and discussed daily in stand-up meeting. Monthly follow up where the monitored in Performance Improvement Committee meetings.  When the way of the provided in the control of the performance Improvement Committee meetings.	aily by vill	5-22-09

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DEPARTMENT OF HEALTH AND HUM SERVICES
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	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		G	COMPLETED C	
		295044	B. WI	G_		1	/ 1/2009
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA				19	EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434		
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F 157	that followed the rerenal failure. He the renal failure. He the not aware that the involved with the reagreed to call the reson-in-law further him to report that a nephrologist to ser facility emergency reportedly called a determine whether the hospital. The that the nurse ther hospital to send the son-in-law reporteresident to the close reportedly passed review revealed a that the resident hof death was perited. Review of Resider entries made into the following: 2/25/09 - the psycresident and docu "underhydrated?" 2/26/09 - "Patient fluids Increased distension" 2/27/09 - "the resident chest x-ray ordered loss 31 pounds" 3/7/09 - "Resident and oriented to seand oxygen saturation and resident and oxygen saturation"	esident for treatment of his nen reported that the nurse was resident had a nephrologist esident's care. The nurse then nephrologist. The resident's reported that the nurse called she was directed by the nd the resident to an acute care department. The nurse then a dialysis nurse consultant to ror not to send the resident to resident's son-in-law reported in called back to ask what he resident to, and the dialysis nurse consultant to resident's son-in-law reported in called back to ask what he resident to, and the dialysis nurse consultant to resident's son-in-law reported in called back to ask what he resident to, and the dialysis nurse consultant to resident to ask what he resident to ask what he resident to and the dialysis nurse consultant to acute the resident to ask what he resident to and the dialysis nurse consultant to resident's son-in-law reported and that he told her to send the sest hospital. The resident away on 3/11/09. Record death certificate that reported and expired and that the cause	F	157			

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED
	205044	B. WING	C

295044

NAME OF PROVIDER OR SUPPLIER

#### **HEARTHSTONE OF NORTHERN NEVADA**

STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD **SPARKS, NV 89434** 

TICAR HISTORE OF HORTHERIN HETADA			SPARKS, NV 89434				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 157	Continued From page 4	F 157	7				
	evaluation."						
	No evidence was found that the nursing staff had						
	contacted the physician related to a change in Resident #2's condition prior to 3/7/09. No						
	evidence was found that the resident's primary						
	physician had been aware of the psychiatrists						
	impression on 2/25/09.						
	Resident #3						
	Resident #3 was admitted to the facility on						
	3/18/09, with diagnoses including end-stage renal						
	disease requiring peritoneal dialysis, diabetes mellitus and peripheral vascular disease. The						
	resident was dependent for all peritoneal dialysis						
	needs.						
	Record review revealed a document titled						
	"Nursing Assessment" that was completed upon						
	Resident #3's admission on 3/18/09 that read:						
	"Section 3. Vital Signs: temperature - 98.0 Fahrenheit		281				
	Section 8. Physical Assessment:		~				
	A. Neuro/Cognitive: independent in decision						
	making with "decisions being consistent/reasonable."						
	E. Pain: denies pain on admission						
	J. Gastrointestinal: no problems documented"						
	Record review revealed that Resident #3 had						
	been transferred to an acute care facility on						
	4/4/09, with a temperature of 100.3 Fahrenheit.						
	Record review revealed the following nurse's						
	notes entries:						
	3/23/09 - "Has disorientation at times." 3/24/09 - "Resident very needy, on the call light						
	every 10 minutes."						

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CENTER	MENT OF HEALTH RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	AND HUMA ERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	ILDIN	PLE CONSTRUCTION	FORM OMB NO.  (X3) DATE SL COMPLE	
		295044	B. WI	1G		04/21/2009	
	ROVIDER OR SUPPLIER  STONE OF NORTHE	RN NEVADA		19	REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD SPARKS, NV 89434		
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F 157	shoulder pain." 3/28/09 - "Medicate 3/31/09 - "Resident Found medications	n moaning, complains of ed for pain in left shoulder." t difficult today. Not compliant. in his bed. Restless early elp constantly. Dialysis	F	157			

4/4/09 night shift: temperature - 99.1 Fahrenheit
Record review revealed the following entries into the physical therapy weekly summary:
3/20/09 - 3/26/09: "Patient has been ill intermittently...but puts effort towards his exercises ... throughout the day and tries his best without trying to regurgitate onto his caregivers."
3/27/09 - 4/2/09: "Actively participated in three of

3/24/09 night shift: temperature - 99.4 Fahrenheit 3/26/09 night shift: temperature - 99.1 Fahrenheit

Record review revealed the following:

Record review revealed no evidence that the physician had been made aware of Resident #3's condition changes prior to the day that the resident was transferred to the acute care facility.

five treatments due to ... bilateral shoulder pain."

The Director of Nursing (DON) was interviewed on 4/9/09 at 11:20 AM, and reported that signs and symptoms to look for that may be indicative of peritonitis included: Distension or tenderness of the abdomen, nausea or vomiting, diarrhea, shoulder pain, elevated temperature, anxiety, change in level of consciousness, confusion, or draining of cloudy dialysate.

Record review of a physician's progress note dated 3/26/09, revealed: "had vomiting after therapy."

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DEPARTMENT OF HEALTH AND HUI	SERVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION	COMPLETED	
		295044	B. WI	IG		04/21	
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE OF NORTHERN NEVADA			•	19	EET ADDRESS, CITY, STATE, ZIP CODE 150 BARING BLVD PARKS, NV 89434		
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F 157	Continued From pa	age 6	F	157			i
	and reported that F	rviewed on 4/9/09 at 11:20 AM, Resident #3 had been admitted acility on 4/4/09, with a nitis.					
	revealed that on 4/department physic "Assessment: 1. Sepsis, source passociated pneum Emergency Depar	peritonitis versus health care onia.					
		ealed that Resident #3 was still acute care facility on 4/20/09.		ļ		į	
F 309			F	309	F 309 Quality of Care		
SS=G	Each resident must provide the necess	st receive and the facility must sary care and services to attain			Resident # 1 and # 2 hav discharged from the facili		
	or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.				Residents residing in the that receive peritoneal dia have the potential to be affected.	facility alysis	5-12-09
	by: Based on intervieve policy and procedifacility failed to procedule.	eNT is not met as evidenced w, record review, and review of ure and industry standards, the ovide necessary care and peritoneal dialysis for 2 of 7			The measures in place ar follows:  Re-educated Nursing staf the policy and procedure peritoneal dialysis on 4/16 Director of Education.	ff on on	
	sampled residents	s (#2, #3).	İ		a de la constantion.		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.				(X3) DATE SURVEY COMPLETED	
		295044 B. WING			C 04/21/2009		
	ROVIDER OR SUPPLIER			19	EET ADDRESS, CITY, STATE, ZIP CODE 050 BARING BLVD PARKS, NV 89434	04/2	1/2009
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F 309	Resident #2  Resident #2 was ad 1/15/09, with diagnoral disease, failure to the atherosclerosis, confibrillation, anemia, resident's legal representation of the community for scontracting an infector review reversident assessme 4. "Cognitive skills dated 1/22/09, that been independent "decisions being contracting an infector review reversident assessme 4. "Cognitive skills dated 1/22/09, that been independent "decisions being contracting and the staff names/faces, decision making - inursing summary of memory recall - standard memory recall	dmitted to the facility on oses including end stage renal hrive, coronary ngestive heart failure, atrial and hypothyroidism. The resentative had been eal dialysis for the resident in six years, without the resident etion.  The resident was a set of the resident in six years, without the resident etion.  The resident was a set of the resident in six years, without the resident etion.  The resident was a set of the resident in six years, without the resident etion.  The resident was a set of the resident had in decision making with ensistent/reasonable."  The realed a weekly nursing the resident was a set of th	F3	809	Licensed Nursing staff will had competency skills checklist of connecting and disconnecting CAPD residents from treatmed and policy on appropriate method and time of using globy Director of Education/designee.  Chart of a resident receiving peritoneal dialysis will be scrubbed by Director of Nursing/designee for completeness of documentat within 24 hours of admission and ongoing.  Daily weights of residents or CAPD will be reported to the Director of Nursing/designee and dietician/designee to address weight changes per policy and procedures on we management. In addition nephrologist and dialysis dietician will be notified for collaborative approach on weight management.	on g ent oves	

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	A. BUILDING				C 4/2000	
NAME OF PROVIDER OR SUPPLIES	1	s	TREET ADDRESS, CITY, STATE, ZIP CO		1/2009	
HEARTHSTONE OF NORTH	ERN NEVADA		1950 BARING BLVD SPARKS, NV 89434			
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the facility contact notify him that the refusing to take he reported that the progressively work saturation of 74% in the morning on nurse had stated condition had detacked him if he will have hospital. The resistant he directed to that follows the refailure. He then refailure. He then refailure with the agreed to call the son-in-law further him to report that nephrologist to se facility emergency reportedly called determine whether the hospital. The that the nurse the hospital to send that to the closest hospital to send that to the closest hospital to send that to the closest hospital away on a death certificate had expired and peritonitis.  Review of Reside entries made into the following:	page 8 and reported that a nurse from ted him on 3/6/09 at 8:00 AM, to a resident was coughing and its medications. The son-in-law resident had become se overnight, with an oxygen and the nurse had called again 3/7/09. He reported that the to him that the resident's eriorated and that the nurse had could like her to send him to the ident's son-in-law then reported ne nurse to call the nephrologist esident for treatment of his renal eported that the nurse was not sident had a nephrologist resident's care. The nurse then nephrologist. The resident's reported that the nurse called she was directed by the end the resident to an acute care of department. The nurse then a dialysis nurse consultant to be or not to send the resident to a resident's son-in-law reported en called back to ask what the resident to, and the son in the told her to send the resident spital. The resident reportedly 3/11/09. Record review revealed that the cause of death was tent #2's medical record revealed that the nurse's notes that contained chiatrist did a consult with the	F 30	The Nursing Assessment Coordinator will be response to oversee that care plant reflect the care provided each CAPD resident.  Staff will be re-educated proper hand washing techniques with return demonstration by Direct Education/designee by Peritoneal residents can will be reviewed in their Quality of Care meeting reported during monthly Performance Improvem meetings.  The Director of Nursing designee will monitor the process on an ongoing	ensible as for on or of 5/22/09. re status monthly and reent	10 g	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
		295044	B. WING			04/21/2009	
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA		RN NEVADA		19	EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	fluids Increased distension"  2/27/09 - "the resident remperature"  3/6/09 - "Resident chest x-ray ordere loss 31 pounds"  3/7/09 - "Resident and oriented to se and oxygen satural labored breathing; evaluation."  No evidence was contacted the phyre Resident #2's conevidence was four physician had been impression on 2/2  Record review reverse therapy. The care "Goals: will not exsecondary to dialy Approach:  1. Resident will be on treatment days 2. Resident will be not in the facility a 3. Avoid taking ble injections over she she cord review reverse reactions.  Record review reverse resident will be not in the facility a 3. Avoid taking ble injections over she she cord review reverse reactions.	continues to not eat takes some apical rate, abdominal dent had an elevated agitated; resident coughing, d to rule out pneumonia; weight agitated, yelling for help; alert lf, skin pale; breathing labored ation 74%; skin ash color with sent to emergency room for found that the nursing staff had sician related to a change in dition prior to 3/7/09. No not that the resident's primary in aware of the psychiatrist's 5/09.  The ealed a care plan for Resident oped for outpatient dialysis a plan revealed the following: perience complications asis for 90 days.  The transported to dialysis center is a provided with take out meals if a transported to dialysis center is a provided with take out meals if a transported to dialysis center is a provided with take out meals if a transported to dialysis center is a provided with take out meals if a transported to dialysis center is a provided with take out meals if a transported to dialysis center is a provided with take out meals if a transported arm.	F	309			

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# DEPARTMENT OF HEALTH AND HUM, BERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED C		
		295044	B. WI	NG _		1	/2009
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	3/18/09, with diagral disease requiring profiles and periph resident was dependeds.  Record review revelopments.  Record review revelopments.  Resident #3's admarce "Section 3. Vital Siffahrenheit Section 8. Physica A. Neuro/Cognitive making with "decist consistent/reasona E. Pain: denies pa J. Gastrointestinal Record review revelopments been transferred to 4/4/09, with a temporate sentries: 3/23/09 - "Has disa/24/09 - "Resider every 10 minutes." 3/25/09 - "Keeps of shoulder pain." 3/28/09 - "Medicata/3/31/09 - "Resider Resider	dmitted to the facility on loses including end-stage renal peritoneal dialysis, diabetes heral vascular disease. The indent for all peritoneal dialysis ealed a document titled ent" that was completed upon hission on 3/18/09 that read: gns: temperature - 98.0 all Assessment: exindependent in decision sions being able." in on admission in on problems documented an acute care facility on perature of 100.3 Fahrenheit. In ealed the following nurse's corientation at times."	F	309			
		elp constantly. Dialysis					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OFNT11

Facility ID: NVN556S

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# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2009 FORM APPROVED OMB NO. 0938-0391

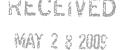
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI		IPLE CONSTRUCTION  NG	COMPLE	TED
		295044	B. WING			04/21	; /2009
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA		RN NEVADA	<del></del>	1	REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		ULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 11	F:	309			
	3/24/09 night shift: 3/26/09 night shift: 4/4/09 - 3/26/09: 'A five treatments due Record review reversident was trans: The Director of Nu on 4/9/09 at 11:20 and symptoms to lead of peritonitis included the abdomen, naus shoulder pain, elever change in level of draining of cloudy Record review of a dated 3/26/09, reverties and reported that I	a physician's progress note ealed: "had vomiting after erviewed on 4/9/09 at 11:20 AM, Resident #3 had been admitted					
29	to the acute care for diagnosis of perito	acility on 4/4/09, with a nitis.					
52	Review of Resider	nt #3's acute care record					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OFNT11

Facility ID: NVN556S

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DEPARTMENT	OF HEALTH	AND HUM	SERVICES
CENTERS FOR	MEDICARE	& MEDICA	D SERVICES



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	INUMBER:   ` ´		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00-044	A. BUILDING B. WING		·	С	
WASS 05 5	200/4050 00 0000 150	295044				04/21	/2009
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE OF NORTHERN NEVADA			19	EET ADDRESS, CITY, STATE, ZIP CODE 50 BARING BLVD PARKS, NV 89434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	department physical "Assessment:  1. Sepsis, source passociated pneumonia per	5/09, the emergency an recorded:  peritonitis versus health care onia. Iment Course: Funt 14,000. X-ray was clear  pealed that Resident #3 was still acute care facility on 4/20/09.  Iment Coordinator was (709 at 11:00 AM, and reported the registered nurses (RNs) had related to peritoneal dialysis. The facility had a consultant is center come in and train the to peritoneal dialysis.  It is consultant's training outline to peritoneal dialysis.  AM, the dialysis consultant ind reported that he does the peritoneal dialysis.  AM, the dialysis consultant ind reported that he does the procedures because the esis a common source of asked if the procedures are to g aseptic technique, he replied	<b>F</b> :	309			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OFNT11

Facility ID: NVN556S

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DEPARTMENT OF HEALTH AND HUM	BERVICES
CENTERS FOR MEDICARE & MEDICALL	SERVICES

295044 B. WING	04/21/2009
HEARTHSTONE OF NORTHERN NEVADA	RESS, CITY, STATE, ZIP CODE
	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 309 Continued From page 13 The Staff Development Coordinator was interviewed and reported that the nurses were instructed not to wear gloves because the powder inside of the gloves is a common cause of peritonitis.  Record review revealed no evidence that staff were wearing gloves while performing peritoneal dialysis procedures.  Review of the facility's policies and procedures revealed a policy and procedure dated 2004, titled: "Nursing Standards of practice, Subject: Dialysis, Peritoneal (CAPD) Standard:  1. The qualified nursing staff will provide care as ordered by a physician for patients/residents requiring peritoneal dialysis that allows them to maintain their highest practicable level of function and health.  2. The qualified nursing staff will follow the (corporate) guidelines.  3. The health care center will obtain the Resident Acknowledgement of Informed Consent Form #FFNP006  4. Refer to the Staff Development Standards of Practice: #24 Competency for Peritoneal Dialysis."  "Description: Infection control practices and technique are essential to prevent the occurrence of peritonitis which often may prevent patients/residents from continuing to use peritoneal dialysis as a treatment modality.  Staff who provide care must receive specialized training so they possess advanced skill levels	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OFNT11

Facility ID: NVN556S

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# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 05/19/2009 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTI		A. BUILDING			COMPLETED  C  04/21/2009		
	ROVIDER OR SUPPLIER  STONE OF NORTHE	RN NEVADA		19	EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	to be removed.  Dialysis Exchange. C. Wash hands, do gloves. Both licensmask. N. Don sterile glov  Review of a peer mand. Preventing Bacter Resistance in Dialy following: "Strategy 4: Preverance Content of the Centers for Dialy following patterns of the Content	sterile gloves see is needed to determine fluid see is needed to determine fluid on mask and non-sterile sed nurse and patient/resident ses." seview article published by the Coalition dated 12/02, titled: rial Infections and Antimicrobial yeis Patients," revealed the sention seese Control and Prevention dis wearing gloves at all times sients or dialysis equipment to by contaminants too small to	F	809				
F 325 SS=G	\','		F	325	F 325			
53 <b>=</b> G	Based on a reside assessment, the faresident - (1) Maintains accestatus, such as bounless the residen demonstrates that	nt's comprehensive acility must ensure that a eptable parameters of nutritional dy weight and protein levels, t's clinical condition this is not possible; and erapeutic diet when there is a			Resident # 1 and resident have been discharged facility.  Residents residing in the have the potential to be affected.	from the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OFNT11

Facility ID: NVN556S

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# DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/19/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
		295044	B. WII	IG		04/21	/2009
	ROVIDER OR SUPPLIER  STONE OF NORTHE	RN NEVADA		19	EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	Continued From pa nutritional problem.		F	325	The measures in place are a follows:	35	
	This REQUIREMENT is not met as evidenced by: Based on record review, interview, policy review, and review of industry standards the facility failed to ensure adequate interventions to prevent a significant weight loss for 2 of 7 sampled residents (#1, #2).  Findings include: Resident #1 Resident #1 Resident #1 was admitted to the facility on 11/10/08, with diagnoses including ulcerations of the lower extremities, protein calorie malnutrition, depression, and Methicillin resistant staphylococcus aureus (MRSA) infection of lower extremity wound.				Registered Dietician will per a nutritional evaluation of all residents admitted to the fac	ļ	
					Weekly weight meetings will continue with review of all weight fluctuations and appropriate interventions will implemented.		5-22-69
					Monitoring will occur in daily stand up meetings, weekly weight meetings, Quality of Care Meetings	!	
	inches in height.  Record review reviews checked on the				Registered Dietician will fol facility policy and procedure and industry standards.	low es	
	11/10/08 (admission 11/11/09: 193 pour 11/12/08: 193 pour 11/19/08: 192 pour 12/11/08: 133 pour 12/11/08: 133 pour 12/17/08: 133 pour 12/17/08	nds nds nds nds nds			Performance Improvement Committee will review and monitor monthly.		
	12/24/08: 138 pour 1/1/09: 146 pound 1/8/09: 138 pound 1/21/09: 137 poun	s s	<u>i</u>		Without hopensibile is assigned to desilita	over Alle	9

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OFNT11

Facility ID: NVN556S

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# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 05/19/2009 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		295044	1	B. WING		04/21/2009	
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE OF NORTHERN NEVADA		<b>!</b>	19	REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	2/1/09: 140 pounds Record review revelody weight was 1st further revealed the pounds, or 26.4% as month period.  Record review revelot that was not dawill stabilize at 190 included: "4 ounce times daily betwee meals and offer alt 75%, offer snacks lunch and dinner, rephysician, dieticiar.  The dietitian was in AM, and reported that "he wante pounds." She furth aggressive with the because she felt the inaccurate. She recommend that the calibrated.  Resident #2  Resident #2  Resident #2 was an 1/15/09 with diagond disease, failure to atherosclerosis, of fibrillation, anemia resident's legal resid	ealed that the resident's usual 90 pounds. Record review at the resident had lost 53 of his usual body weight over a realed a care plan for Resident ted. It listed a goal of "weight pounds." Interventions s of house supplement three in meals, encourage intake of ternate if (intake) less than per protocol, ice cream with report weight change to in, and family."  Interviewed on 4/9/09 at 11:30 that Resident #1 had stated to do be at or around 190 their reported that she did not get the resident's nutritional care that the scale must have been reported that she did not not see scale be checked or and hypothyroidism. The presentative had been real dialysis for the resident in	F	325			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OFNT11

Facility ID: NVN556S

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DEPARTMENT OF HEALTH AND HUN	SERVICES
CENTERS FOR MEDICARE & MEDICALD	SERVICES

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` ′	IULTIPL ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295044	B. WII	1G		1	1/2009
	ROVIDER OR SUPPLIER			195	ET ADDRESS, CITY, STATE, ZIP CODE 50 BARING BLVD PARKS, NV 89434	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	inches in height.  Record review review reviews checked on the street of	realed that Resident #2's weight ne following dates: ds	F	325			

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DEPARTMENT OF HEALTH AND HUM ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295044	B. WI			- 1	C 1/2009
	PROVIDER OR SUPPLIER			19	EET ADDRESS, CITY, STATE, ZIP CODE 150 BARING BLVD PARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 325	Resident #2's lega interviewed and re have large weight to the facility. He registered failure.  The dietitian was in AM, and reported the Resident #2 had be had completed a discompleted and She reported that information on Resident she routinely dietary evaluation "must have missed Review of the facily procedures reveal 2008, titled: "Subject: Referrals Procedures:  6. At his or her nearegistered dietitian nutritional assessmant be commended the assessment be commended the	I representative was ported that the resident did not fluctuations prior to admission reported that the resident's ed frequently at home due to his interviewed on 4/9/09 at 11:30 that she was aware that een losing weight and that she lietary consult for the resident. she did not write any sident #2's medical record, but writes updates on the initial record. She reported that she	F	325			

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## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295044	B. WI			04/24	/2009
	ROVIDER OR SUPPLIER		<u>l</u>	19	EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434	04/21	12009
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	month thereafter domany patients and Review of "Nutrition Lippincott Sixth Ed the following industriable 16-13 Role	ue to the short length of stay of their high level of acuity." In and Diagnosis Related Care," Ition, Copyright 2008, revealed	F	325			
	optimal nutritional l calories, protein, se calcium, and phos individualized nutri nutritional interven	neters are necessary to provide health, including monitoring of odium, fluid, potassium, phorus, as well as other ents. Consider all modes of tion; use that which is best atient and the least invasive.					
	peritoneal dialysis. recognize significa (adjusted edema-f Discuss actions to	are not always needed with Patient should learn how to int changes in dry weight ree body weight) or food intake, be taken. Usually, three to four intermittent peritoneal dialysis is					
F 441 SS=G	The facility must e infection control pr safe, sanitary, and to prevent the dev disease and infect an infection control investigates, control the facility; decided isolation should be		F	441	Resident # 1 and have been discharged from facility.  Residents residing in the that receive peritoneal dia have the potential to be affected.	m the facility	5-12-9

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Event ID: OFNT11

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## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1.	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295044	B. WI	NG		04/21	C 1 <b>/2009</b>
	PROVIDER OR SUPPLIER	RN NEVADA	s		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441		age 20 related to infections.	F	441	The measures in place are as follows:	3	
	by: Based on interview procedure review, facility failed to pre	NT is not met as evidenced  v, record review, policy and and industry standards, the event the development and sease and infection related to			Re-educated Nursing staff or the policy and procedure on peritoneal dialysis on 4/16/09 Director of Education.	Į.	
	peritoneal dialysis (#2, #3). Findings include: Resident #2 Resident #2 was a 1/15/09, with diagral disease, failure to	for 2 of 7 sampled residents  admitted to the facility on noses including end stage renal thrive, coronary	82		Licensed Nursing staff will he competency skills checklist connecting and disconnecting CAPD residents from treath and policy on appropriate method and time of using go by Director of Education/designee.	ng nent	· (4)
	fibrillation, anemia resident's legal reperforming periton	ongestive heart failure, atrial, and hypothyroidism. The presentative had been heal dialysis for the resident in six years, without the resident ection.			Chart of a resident receivir peritoneal dialysis will be scrubbed by Director of Nursing/designee for completeness of documen within 24 hours of admissi	ntation	
2	resident assessmed. Cognitive skills dated 1/22/09, that been independent "decisions being of Record review revisummary dated 1/2 checked: "Alert, mistaff names/faces decision making -	realed a Minimum Data Set ent for Resident #2: Section B., for daily decision making, at showed that the resident had in decision making with consistent/reasonable."  realed a weekly nursing (22/09, with the following boxes nemory recall - current season, that he was in a nursing home; independent." A weekly dated 1/28/09, read: "Alert,			and ongoing.  Utfertin date of 15 5/2+109 per 18 10 5/2+109 per 18 10 10 10 10 10 10 10 10 10 10 10 10 10	Janphine Itmm n m blill Witte III Ney "	9

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#### DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		С	:
<del>.</del>		295044	B. WING	·	04/21	/2009
	ROVIDER OR SUPPLIER  STONE OF NORTHE	RN NEVADA		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	memory recall - stanursing home; decine Record review revenote dated 1/19/09 peritoneal catheter.  Record review revenote dated 1/19/09 peritoneal catheter.  Record review revenote her transferred to 3/7/09, for coughing On 4/6/09 at 10:30 was interviewed and the facility contacter notify him that the refusing to take his reported that the reprogressively wors saturation of 74% a in the morning on 3 nurse had stated to condition had deter asked him if he wo hospital. The residition had deter asked him if he wo hospital. The residition had deter asked him if he wo hospital. The residition had deter asked him if he wo hospital. The residition had deter asked him if he wo hospital. The residition had deter that follows the residinvolved with the residing further residing to call the residing	ff names/ faces, that he is in a sion making - independent."  caled a physician's progress that read: "Abdomen: normal, "  caled that Resident #2 had an acute care facility on g and hypoxia.  AM, Resident #2's son-in-law d reported that a nurse from d him on 3/6/09 at 8:00 AM, to resident was coughing and medications. The son-in-law resident had become e overnight, with an oxygen and the nurse had called again 6/7/09. He reported that the nurse had uld like her to send him to the ent's son-in-law then reported enurse to call the nephrologist ident for treatment of his renal ported that the nurse was not dent had a nephrologist resident's care. The nurse then rephrologist. The resident's reported that the nurse called he was directed by the did the resident to an acute care department. The nurse then dialysis nurse consultant to or not to send the resident to esident's son-in-law reported called back to ask what	F 44		e e e r eight	
	hospital to send the	e resident to, and the		100		

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DEPARTMENT OF HEALTH	AND HUN	SERVICES
CENTERS FOR MEDICARE	& MEDICAID	SERVICES

AND PLAN OF CORRECTION  (X1) PROVIDERSUPPLIER CLIA (X2) MOLTI (X2) MOLTI (X2) MOLTI (X3) MOLTI (X3) MOLTI (X4) MOLTI (X4) MOLTI (X5) MOLTI (X6) MOLTI (X7) MOLTI (X8) MOLTI (X8) MOLTI (X9)		JILDING		COMPLETED						
		295044	B. WI	1G			) 1/2009			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C 1950 BARING BLVD SPARKS, NV 89434		50 BARING BLVD	<del></del>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	son-in-law reporteresident to the cloreportedly passed review revealed athat the resident hof death was perit Review of Reside entries made into the following:	d that he told her to send the sest hospital. The resident away on 3/11/09. Record death certificate that reported ad expired and that the cause onitis.  In #2's medical record revealed the nurse's notes that contained	F	441						
	resident and docu "underhydrated?" 2/26/09 - "Patient fluids Increased distension" 2/27/09 - "the resi temperature" 3/6/09 - "Resident chest x-ray ordere loss 31 pounds" 3/7/09 - "Resident and oriented to se and oxygen sature	continues to not eat takes some dapical rate, abdominal dent had an elevated agitated; resident coughing, ed to rule out pneumonia; weight agitated, yelling for help; alert elf, skin pale; breathing labored ation 74%; skin ash color with sent to emergency room for								
	contacted the phy Resident #2's cor evidence was fou	found that the nursing staff had sician related to a change in edition prior to 3/7/09. No and that the resident's primary en aware of the psychiatrist's 15/09.								
	#2 that was developed therapy. The care	vealed a care plan for Resident oped for outpatient dialysis plan revealed the following: operience complications ysis for 90 days.								

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CENTER STATEMENT	MENT OF HEALTH RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	AND HUM SERVICES & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  295044	(X2) MI A. BUII B. WIN	DING	CONSTRUCTION	FORM OMB NO. (X3) DATE SI COMPLE	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
HEARTH	STONE OF NORTHER	RN NEVADA			BARING BLVD ARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	on treatment days.  2. Resident will be not in the facility at 3. Avoid taking blockinjections over shurd 5. After dialysis treat adverse reactions to the Record review reves shunt, was not transitionally sis was performed at the Resident #3  Resident #3  Resident #3 was at 3/18/09, with diagnorm disease requiring performed and peripher resident was depended.  Record review rever "Nursing Assessment Resident #3's admit at the Resident #3's admit at	transported to dialysis center provided with take out meals if mealtimes. od pressures or giving nted arm. atment observe resident for to treatment." ealed that Resident #2 had no sported out, as his peritoneal	F4	141			

Record review revealed that Resident #3 had been transferred to an acute care facility on

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Section 8. Physical Assessment:

E. Pain: denies pain on admission

making with "decisions being consistent/reasonable."

A. Neuro/Cognitive: independent in decision

J. Gastrointestinal: no problems documented"

4/4/09, with a temperature of 100.3 Fahrenheit.

Fahrenheit

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Facility ID: NVN556S

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DEPARTMENT OF HEALTH	AND HUM	BERVICES
CENTERS FOR MEDICARE	& MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BUI		PLE CONSTRUCTION  G	COMPLETED		
		295044	B. WII	NG _		04/21	5 1/2009
	OVIDER OR SUPPLIER	RN NEVADA	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD SPARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	notes entries: 3/23/09 - "Has disco 3/24/09 - "Resident every 10 minutes." 3/25/09 - "Keeps of shoulder pain." 3/28/09 - "Medicate 3/31/09 - "Resident Found medications shift. Calling for he machine keeps bee Record review reve 3/24/09 night shift: 3/26/09 night shift: 4/4/09 night shift: to Record review reve the physical therap 3/20/09 - 3/26/09: "A five treatments due Record review reve physical therap 3/27/09 - 4/2/09: "A five treatments due Record review reve physician had bee condition changes resident was trans The Director of Nu on 4/9/09 at 11:20 and symptoms to I of peritonitis includ the abdomen, nau shoulder pain, elev	ealed the following nurse's rientation at times." t very needy, on the call light n moaning, complains of ed for pain in left shoulder." t difficult today. Not compliant. is in his bed. Restless early elp constantly. Dialysis	F	441			

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	MENT OF HEALTH	AND HUM ERVICES  & MEDICAID SERVICES				FORM /	4PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) N		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY TED
		295044	B. WII	NG _		04/21	) 1 <b>/2009</b>
NAME OF P	ROVIDER OR SUPPLIER	:	<del></del>		TREET ADDRESS, CITY, STATE, ZIP CODE		
HEARTH	STONE OF NORTHE	RN NEVADA			1950 BARING BLVD SPARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 25	F	44	1		
	draining of cloudy of	dialysate.					
		physician's progress note ealed: "had vorniting after			,		
	and reported that F	rviewed on 4/9/09 at 11:20 AM, Resident #3 had been admitted acility on 4/4/09, with a nitis.					
	revealed that on 4/1 department physici "Assessment: 1. Sepsis, source p associated pneumo Emergency Depart	peritonitis versus health care	į				
	Record review revealed that Resident #3 was still an inpatient at the acute care facility on 4/20/09.						
	interviewed on 4/9/ that almost all of the completed training She reported that the from a local dialysity facility staff related	ment Coordinator was 709 at 11:00 AM, and reported registered nurses (RNs) had related to peritoneal dialysis. The facility had a consultant is center come in and train the to peritoneal dialysis.					
	revealed that he re	rsis consultant's training outline ecommended that staff not wear the peritoneal dialysis					

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On 4/9/09 at 11:40 AM, the dialysis consultant was interviewed, and reported that he did

procedures.

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DEPARTMENT OF HEALTH AND HUM/ ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					0	PRINTED: 05/19/2009 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		295044	B. WING			04/21/2009		
	ROVIDER OR SUPPLIER	RN NEVADA	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434		-			
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIES		- ID	ID PROVIDER'S PLAN OF CO		PRRECTION (X5)		

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 Continued From page 26 F 441 recommend that staff not wear gloves during the peritoneal dialysis procedures because the powder in the gloves was a common source of peritonitis. When asked if the procedures were to be performed using aseptic technique, he replied "no, it is a clean procedure." The DON reported that she performed the peritoneal dialysis procedures on week-days. She reported that she did not wear gloves while performing peritoneal dialysis procedures. The Staff Development Coordinator was interviewed and reported that the nurses were instructed not to wear gloves because the powder inside of the gloves was a common cause of peritonitis. Record review revealed no evidence that staff were wearing gloves while performing peritoneal dialysis procedures. Review of the facility's policies and procedures revealed a policy and procedure dated 2004, titled: "Nursing Standards of practice, Subject: Dialysis, Peritoneal (CAPD)," indicated: "Standard: 1. The qualified nursing staff will provide care as ordered by a physician for patients/residents requiring peritoneal dialysis that allows them to maintain their highest practicable level of function and health. 2. The qualified nursing staff will follow the (corporate) guidelines. 3. The health care center will obtain the Resident Acknowledgement of Informed Consent Form 4. Refer to the Staff Development Standards of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	295044		B. WING			04/21/2009	
	PROVIDER OR SUPPLIER  HSTONE OF NORTHE	RN NEVADA		19	EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		OULD BE	(X5) COMPLETION DATE	
F 44	Practice: #24 Compialysis."  "Description: Infection control pressential to preven which often may present modality  Staff who provide of training so they posteriore providing performent:  C. sterile and non-Practice Guidelines 5. Assess A. Weight: Baseling to be removed.  Dialysis Exchange C. Wash hands, dogloves. Both licensmask. N. Don sterile gloves. Review of a peer removed.  Review of a peer removed.	actices and technique are it the occurrence of peritonitis revent patients/residents from peritoneal dialysis as a care must receive specialized ssess advanced skill levels eritoneal dialysis.  sterile gloves s: e is needed to determine fluid con mask and non-sterile sed nurse and patient/resident	F	141			

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"Strategy 4: Prevention

-The Centers for Disease Control and Prevention (CDC) recommends wearing gloves at all times when touching patients or dialysis equipment to prevent infections by contaminants too small to

following:

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	IMENT OF HEALTH RS FOR MEDICARE	I AND HUM/ ERVICES  & MEDICAID SERVICES					APPROVED 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	295044		B. WI	NG _		C 04/21/2009		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD			
HEARTH	STONE OF NORTHE	RN NEVADA	SPARKS, NV 89434					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	ID PROVIDER'S PLAN OF CORPRETIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMPLÉTION		
F 441	Continued From pa	ge 28	F	441				
	be seen with the na	aked eye."						
	Complaint #21850							
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